TESTIMONY OF GREGORY L. SHANGOLD, MD, FACEP
PAST-PRESIDENT CONNECTICUT COLLEGE OF EMERGENCY PHYSICIANS
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Good afternoon Committee members. Thank you for the opportunity to present my testimony about Medicaid patients in Connecticut's emergency departments. I had the privilege of meeting with Ms. Duffy and Ms. Conlin to discuss this very important issue.

Emergency Departments in the State of Connecticut provide around the clock medical services to our citizens. Connecticut's emergency departments see approximately 1.75 million patients every year, which is over 4,600 patients per day. We are society's safety net for a fragile and fragmented health care system. We care for all patients regardless of the severity of the complaint or the individual insurance status. Life and death decisions are made every day without the benefit of a long-standing doctor-patient relationship or complete knowledge of a patient's medical history. Emergency departments function as both the front line in our struggle to provide health care to a diverse society as well as the final safety net when all options are exhausted. Emergency physicians embrace this call.

A federal law, known as EMTALA, was created in 1986 to provide statutory guidance to ensure compliance with this mission. It mandates that hospitals have personnel to evaluate any patient who presents to an emergency department. It further mandates that hospitals perform all necessary tests to determine the existence of an emergency medical condition, and if present, stabilize the patient. This is all done without consideration of the patient's ability to pay or insurance status. Hospital, emergency physicians or on-call specialists do not have a choice in providing this mandatory evaluation and/or treatment.

According to the Centers for Disease Control, 92% of ED visits required medical attention within 24 hours. Two-thirds of these ED visits occurred when other options were not available to patients such as nights, weekends and holidays. Clearly, from the recent report, Medicaid beneficiaries utilize ED services at a higher rater then non-Medicaid patients. However, I believe it is a mistake to conclude that an emergency visit automatically equates to a failure of the health care system. In this report, emergency department visits only comprised 3.5% of the total Medicaid expenditure. This mimics national trends, which show emergency visits are only 2% of the national healthcare expense. In the first line of the PRI's initial explanation, the word "inappropriate' was used to describe the ED visits being reviewed. When a mammogram or colonoscopy is performed and does not diagnose cancer, no one suggests the test was inappropriate. However, when a 50-year-old patient is evaluated with chest pain and is able to be discharge home because the pain was not from a heart attack, people suggest the visit may be inappropriate. If after all this work we could reduce Medicaid ED visits by 15%, the state would save less than 1% of the Medicaid budget.

Medicaid, and specifically Medicaid recipients, have become under increased scrutiny over the past years as the nation has struggled with reforming the healthcare system. Many experts predict current Medicaid spending to be unsustainable and have looked at it as a place to cut spending, however, Medicaid growth is predicted to climb as uninsured people will be transitioned to Medicaid via the affordable care act. Clinical resources available to

Medicaid beneficiaries are already severely limited. Adding more people without increasing primary care physicians and specialists accepting Medicaid will further exacerbate this inequity. Emergency Departments are bracing for an influx of these new recipients who will have nowhere else to turn other than emergency departments. Massachusetts experienced a 7% rise in ED visits after instituting their universal healthcare policy. Many of these emergency patients will require admission because of the lack of management of chronic conditions.

The irony of this review is that DSS does not recognize emergency physicians and allow them to individually participate with Medicaid. Hospitals must bill for emergency physician's professional services even though one-third of Connecticut's emergency physicians are not employed by hospitals. This does not occur for any other medical specialty. For the past six years emergency physicians have been fighting to be treated like every other physician and be paid for services directly provided to Medicaid beneficiaries.

If the state truly wants to tackle cost and access, they should consider special liability reform. Connecticut is an unfavorable state to practice medicine due to the malpractice environment. Connecticut's emergency care system is at this critical juncture because the current environment has led to a severe lack of access to medical services. In the American College Emergency Physicians' 2009 State of Emergency Care Report, Connecticut ranked 35th in the nation for our medical malpractice environment. Connecticut always ranks as one of the top states in regards to professional liability premiums averaging twice the national average. Furthermore, Connecticut ranks as having one of the highest payouts per claim among all 50 states. Even the small concession passed in the 2005 compromise has been under attack over the past three legislative sessions with attempts to eviscerate the certificate of merit.

Having recognized the unique nature of providing emergency care and in an effort to attract physicians, many states have already enacted professional liability reform. Attracting physicians should be a key strategy of Connecticut's policy makers. The average age of Connecticut's physicians is in the late 50s. All 29 of Connecticut's emergency department medical directors reported a problem with having adequate on-call coverage for specific medical emergencies.

Many states including Texas, Florida, Georgia, South Carolina, West Virginia and Arizona have begun to see significant premium reductions from recently passed malpractice reform legislation. In conjunction with these benefits, physicians seeking to practice in those states are also increasing. Texas passed comprehensive reform in 2003. In the three years following the reform Texan hospitals increased charity care by $594 million.

Another reason to have malpractice reform is because of the enormous cost of defensive medicine. Defensive medicine costs throughout the country are estimated at $100 billion dollars per year. Many opponents to medical malpractice reform attempt to site studies saying the impact is minimal. As a practicing physician, I can unequivocally state I order multiple tests every day purely for defensive medicine purposes.

Frivolous lawsuits are another drain on the health care dollar that could be spent wiser. The UCONN Health Center spent $1.8 million over the past four years defending frivolous malpractice claims. Significant malpractice reform would begin to make a dent in the rising costs of healthcare.

I believe the report's summary is correct; focusing on the behavioral health and the high utilizers will allow for the most impact when considering Medicaid patients using CT's emergency departments. No policy should infringe on the sacred concept of the prudent layperson. Every person in Connecticut should have access to emergency care if the person believes an emergency exists. Based on many factors, the definition of emergency cannot be standardized and that is why the prudent layperson standard was established. Regardless of a patient's insurance status, people must have access to care. Currently, this state has insufficient resources available for patients with Medicaid. Most Medicaid beneficiaries are making a reasonable choice when choosing to be seen in our emergency departments. Saving dollars in health care must occur. A proven strategy is to address the woeful malpractice environment of Connecticut by raising the burden of proof from a preponderance of evidence to clear and convincing evidence. Emergency departments must be considered an essential community service like the fire and police department. It is the safety net for all people in Connecticut and it must be strengthened before it can no longer serve its mission.